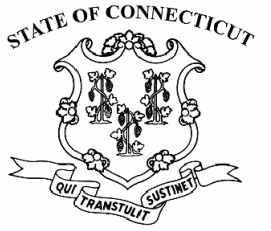

Substitute House Bill No. 5254

Public Act No. 14-235

AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL AND MINOR CHANGES TO THE INSURANCE STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-90a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

As used in sections 38a-90 to 38a-90h, inclusive:

[(a)**]** (1) "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

[(b)**]** (2) (A) "Managing general agent" means any person, firm, association or corporation who manages all or part of the insurance business of an insurer, including the management of a separate division, department or underwriting office and acts as an agent for such insurer whether known as a managing general agent, manager or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium which is equal to or more than five per cent of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with one or more of the following activities related to

the business produced: **[**(1)**]** (i) Adjusts or pays claims in excess of an amount determined by the commissioner; **[**, or (2)**]** or (ii) negotiates reinsurance on behalf of the insurer.

(B) Notwithstanding **[**the above**]** subparagraph (A) of this subdivision, the following persons shall not be considered as managing general agents for the purposes of sections 38a-90 to 38a-90h, inclusive: **[**(A)**]** (i) Any employee of the insurer; **[**(B)**]** (ii) a United States manager of the United States branch of an alien insurer, as defined in section 38a-1; **[**(C)**]** (iii) an underwriting manager **[**which**]** who, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, subject to the Holding Company Regulatory Act, and whose compensation is not based on the volume of premiums written; and **[**(D)**]** (iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or interinsurance exchange under powers of attorney.

[(c)**]** (3) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

Sec. 2. Subsection (f) of section 38a-90d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(f) An insurer shall review its books and records each quarter to determine if any agent has become, by operation of **[**subsection (b)**]** subdivision (2) of section 38a-90a, as amended by this act, a managing general agent. If the insurer determines that an agent has become a managing general agent, the insurer shall promptly notify the agent of such determination and the insurer and agent **[**must**]** shall fully comply with the provisions of sections 38a-90 to 38a-90h, inclusive, **[**within**]** not later than thirty days after such determination.

Sec. 3. Section 38a-216 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

A medical association desiring to form a medical service corporation may incorporate under the general laws of the state governing corporations, but subject to the following provisions: **[**(a)**]** (1) The certificate of incorporation of each such corporation shall have endorsed thereon, or attached thereto, the consent of the Insurance Commissioner, if **[**he**]** the commissioner finds the same to be in accordance with sections 38a-214 to 38a-225, inclusive, as amended by this act, and in the public interest, provided security guaranteeing the performance of the obligations of such corporation shall be furnished in form and amount, not less than five thousand dollars, as the commissioner determines; and **[**(b)**]** (2) such certificate shall include a statement of the territory in which the corporation will operate, the services to be rendered by the corporation and the rates currently to be charged therefor and shall be accompanied by two copies of the contract **[**which**]** that the corporation proposes to make with the subscribers. Such corporation shall include in its bylaws provision for the election of at least three of its policyholders to its board of directors by its members, and failure to include such a provision in such bylaws or to abide by such provision shall be grounds for disapproval by the Insurance Commissioner of any contract it may enter into during the period of such noncompliance.

Sec. 4. Section 38a-601 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

No foreign or alien society shall transact business in this state without a license issued by the commissioner. Any such society may be licensed to transact business in this state upon filing with the commissioner: **[**(a)**]** (1) A certified copy of its charter or articles of incorporation; **[**(b)**]** (2) a copy of its constitution and laws, certified by its secretary or corresponding officer; **[**(c)**]** (3) a power of attorney

appointing the commissioner as its agent for service of process as prescribed in section 38a-25; **[**(d)**]** (4) a statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the commissioner, verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the Insurance Commissioner of this state; **[**(e)**]** (5) a certificate from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to transact business therein; **[**(f)**]** (6) copies of its certificate forms; and **[**(g)**]** (7) such other information as he deems necessary; and upon a showing that its assets are invested in accordance with the provisions of sections 38a-595 to 38a-626, inclusive, 38a-631 to 38a-640, inclusive, and 38a-800. Any foreign or alien society desiring admission to this state shall have the qualifications required of domestic societies organized under said sections.

Sec. 5. Section 38a-603 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

When the commissioner upon investigation finds that a foreign or alien society transacting or applying to transact business in this state: **[**(a)**]** (1) Has exceeded its powers; **[**(b)**]** (2) has failed to comply with any of the provisions of sections 38a-595 to 38a-626, inclusive, 38a-631 to 38a-640, inclusive, and 38a-800; **[**(c)**]** (3) is not fulfilling its contracts in good faith; or **[**(d)**]** (4) is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public, he shall notify the society of his findings, state in writing the reasons for his dissatisfaction and require the society to show cause on a date named why its license should not be suspended, revoked or refused. If on such date the society does not present good and sufficient reason why its authority to do business in this state should not be suspended, revoked or refused, he may suspend or refuse the license of the society

to do business in this state until satisfactory evidence is furnished to him that such suspension or refusal should be withdrawn or he may revoke the authority of the society to do business in this state. Nothing contained in this section shall be taken or construed as preventing any such society from continuing in good faith all contracts made in this state during the time such society was legally authorized to transact business herein.

Sec. 6. Section 38a-976 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

As used in sections 38a-975 to 38a-998, inclusive:

[(a)**]** (1) "Adverse underwriting decisions" means:

[(1)**]** (A) Any of the following actions with respect to insurance transactions involving insurance coverage **[**which**]** that is individually underwritten: **[**(A)**]** (i) A declination or termination of insurance coverage; **[**, (B)**]** (ii) failure of an agent to apply for insurance coverage with a specific insurance institution which the agent represents and which is requested by an applicant; **[**, (C)**]** (iii) in the case of a property or casualty insurance coverage, **[**(i)**]** (I) placement by an insurance institution or agent of a risk with a residual market mechanism, an unauthorized insurer or an insurance institution which specializes in substandard risks, **[**(ii)**]** (II) the charging of a higher rate on the basis of information which differs from that which the applicant or policyholder furnished, or **[**(iii)**]** (III) changing a risk from a preferred rate program to a standard rate program or from a standard rate program to a nonstandard rate program within the same company or between two companies in the same group; and **[**(D)**]** (iv) in the case of a life, health or disability insurance coverage, an offer to insure at higher than standard rates.

[(2)**]** (B) Notwithstanding the provisions of **[**subdivision (1) of this

subsection] subparagraph (A) of this subdivision, the following actions shall not be considered adverse underwriting decisions: [(A)] (i) The termination of an individual policy form on a class or state-wide basis; [, (B)] (ii) a declination of insurance coverage solely because such coverage is not available on a class or state-wide basis; [, or (C)] or (iii) the rescission of a policy.

[(b)] (2) "Affiliate" or "affiliated" has the same meaning [assigned to it] as provided in section 38a-1.

[(c)] (3) "Agent" [shall have] has the same meaning as "insurance producer", as defined in section 38a-702a.

[(d)] (4) "Applicant" means any person who seeks to contract for insurance coverage other than a person seeking group insurance that is not individually underwritten.

[(e)] (5) "Commissioner" means the Insurance Commissioner.

[(f)] (6) "Consumer report" means any written, oral or other communication of information bearing on an individual's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living which is used or expected to be used in connection with an insurance transaction.

[(g)] (7) "Consumer reporting agency" means any person who: [(1)] (A) Regularly engages, in whole or in part, in the practice of assembling or preparing consumer reports for a fee; [, (2)] (B) obtains information primarily from sources other than insurance institutions; [, and (3)] and (C) furnishes consumer reports to other persons.

[(h)] (8) "Control", including the terms "controlled by" or "under common control with", has the same meaning [assigned to it] as provided in section 38a-1.

[(i)**]** (9) "Declination of insurance coverage" means a denial, in whole or in part, by an insurance institution or agent, of requested insurance coverage.

[(j)**]** (10) "Individual" means any person who: **[**(1)**]** (A) In the case of property or casualty insurance, is a past, present or proposed named insured or certificate holder; **[**(2)**]** (B) in the case of life, health or disability insurance, is a past, present or proposed principal insured or certificate holder; **[**(3)**]** (C) is a past, present or proposed policyowner; **[**(4)**]** (D) is a past or present applicant or claimant; or **[**(5)**]** (E) derived, derives or is proposed to derive insurance coverage under an insurance policy or certificate subject to sections 38a-975 to 38a-998, inclusive.

[(k)**]** (11) "Institutional source" means any person or governmental entity that provides information about an individual to an agent, insurance institution or insurance-support organization, other than: **[**(1)**]** (A) An agent; **[**, (2)**]** (B) the individual who is the subject of the information; **[**, or (3)**]** or (C) an individual acting in a personal capacity rather than a business or professional capacity.

[(l)**]** (12) "Insurance institution" means any corporation, limited liability company, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance, including health care centers, as defined in section 38a-175, medical service corporations, as defined in section 38a-214, as amended by this act, managed care organizations, as defined in section 38a-478 and hospital service corporations, as defined in section 38a-199, as amended by this act. It shall not include agents or insurance-support organizations.

[(m) (1)**]** (13) (A) "Insurance-support organization" means any person who regularly engages, in whole or in part, in the practice of assembling or collecting information concerning individuals for the

primary purpose of providing the information to an insurance institution or agent for insurance transactions, including: **[**(A)**]** (i) The furnishing of consumer reports or investigative consumer reports to an insurance institution or agent for use in connection with an insurance transaction; **[**, (B)**]** (ii) the collection of personal information from insurance institutions, agents or other insurance-support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity; **[**, or (C)**]** or (iii) collecting medical record information from, disclosing medical record information to, or collecting medical record information on behalf of an insurance institution or agent in the ordinary course of business, including, but not limited to, utilization review companies, benefit management entities, including, but not limited to, pharmaceutical benefit and disease management entities and information or computer management entities.

[(2)**]** (B) Notwithstanding **[**subdivision (1) of this subsection**]** subparagraph (A) of this subdivision, the following persons shall not be considered "insurance-support organizations" for purposes of sections 38a-975 to 38a-998, inclusive: Agents, government institutions, insurance institutions, medical care institutions, medical professionals, pharmacies, universities and schools.

[(n)**]** (14) "Insurance transaction" means any transaction involving insurance primarily for personal, family or household needs rather than business or professional needs **[**which**]** that involves: **[**(1)**]** (A) The determination of an individual's eligibility for an insurance coverage, benefit or payment; **[**, or (2)**]** or (B) the servicing of an insurance application, policy, contract or certificate.

[(o)**]** (15) "Investigative consumer report" means a consumer report or portion thereof in which information about an individual's character, general reputation, personal characteristics or mode of living

is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances or others who may have such knowledge.

[(p)**]** (16) "Medical-care institution" means any facility or institution that is licensed to provide health care services to individuals, including but not limited to health care centers, home-health agencies, hospitals, medical clinics, public health agencies, rehabilitation agencies and skilled nursing facilities.

[(q)**]** (17) "Medical professional" means any person licensed or certified to provide health care services to individuals, including, but not limited to, a chiropractor, clinical dietitian, clinical psychologist, dentist, nurse, occupational therapist, optometrist, pharmacist, physical therapist, physician, podiatrist, psychiatric social worker or speech therapist.

[(r)**]** (18) "Medical-record information" means personal information **[**which: (1)**]** that: (A) Relates to the physical, mental or behavioral health condition, medical history or medical treatment of an individual or a member of the individual's family; **[**, and (2)**]** and (B) is obtained from a medical professional or medical-care institution, from a pharmacy or pharmacist, from the individual, or from the individual's spouse, parent or legal guardian or from the provision of or payment for health care to or on behalf of an individual or a member of the individual's family. **[**The term**]** "Medical-record information" does not include such information from which personal identifiers that either directly reveal the identity of the patient, or provide a means of identifying the patient, have been removed or have been encrypted or encoded such that the identity of the individual is not revealed without the use of an encryption key or code.

[(s)**]** (19) "Person" has the same meaning **[**assigned to it**]** as provided in section 38a-1.

[(t)**]** (20) "Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health or any other personal characteristics. "Personal information" includes an individual's name and address and "medical-record information" but does not include "privileged information".

[(u)**]** (21) "Policyholder" means any person who: **[**(1)**]** (A) In the case of individual property or casualty insurance, is a present named insured; **[**(2)**]** (B) in the case of individual life, health or disability insurance, is a present policyowner; or **[**(3)**]** (C) in the case of group insurance **[**which**]** that is individually underwritten, is a present group certificate holder.

[(v)**]** (22) "Pretext interview" means an interview where a person, in an attempt to obtain information about an individual, performs one or more of the following acts: **[**(1)**]** (A) Pretends to be someone he is not; **[**, (2)**]** (B) pretends to represent a person he is not in fact representing; **[**, (3)**]** (C) misrepresents the true purpose of the interview; **[**, or (4)**]** or (D) refuses to identify himself upon request.

[(w)**]** (23) "Privileged information" means any individually identifiable information that: **[**(1)**]** (A) Relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual; **[**, and (2)**]** and (B) is collected in connection with or in reasonable anticipation of a claim for insurance benefits or a civil or criminal proceeding involving an individual. **[**; provided information**]** Information otherwise meeting the requirements of this **[**subsection**]** subdivision shall nevertheless be considered "personal information" under sections 38a-975 to 38a-998, inclusive, if it is disclosed in violation of section 38a-988.

[(x)**]** (24) "Residual market mechanism" means an association,

organization or other entity defined or described in sections 38a-328, 38a-329 and 38a-670.

[(y)**]** (25) "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure to pay a premium as required by the policy.

[(z)**]** (26) "Unauthorized insurer" has the same meaning **[**assigned to it**]** as provided in section 38a-1.

Sec. 7. Subsection (a) of section 38a-794 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) Any applicant for a surplus lines broker's license shall be a person, firm, association or corporation who or which is domiciled and maintains an office in this state or a nonresident who or which desires to act within this state, and is licensed as an insurance producer. A surplus lines broker's license shall authorize the licensee to procure, from insurers not authorized to transact business in this state, subject to the restrictions herein provided, policies of insurance against loss from any contingency as provided by the insurance laws of this state, except any insurance coverage which can be placed through a residual market mechanism, as defined in **[**subsection (x) of**]** section 38a-976, as amended by this act.

Sec. 8. Subsection (e) of section 38a-985 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(e) The insurance institution or agent responsible for the occurrence of any action specified in **[**subdivision (2) of subsection (a)**]** subparagraph (B) of subdivision (1) of section 38a-976, as amended by this act, **[**which**]** that is not an adverse underwriting decision shall

provide the applicant or policyholder with the specific reason for its occurrence.

Sec. 9. Subsection (a) of section 38a-988a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) No person, including, but not limited to, insurance institutions, agents, insurance support organizations, health care professionals, medical care centers, pharmacies, pharmaceutical companies, schools and universities, and no person's agent, contractor or employee, shall sell or offer for sale individually identifiable medical record information, as defined in **[**subsection (r) of**]** section 38a-976, as amended by this act. No person shall disclose, for purposes of marketing, individually identifiable medical record information without the prior written consent of the individual to whom the individually identifiable medical record information pertains or, in the case of a minor, of the minor's parent or guardian. Nothing in this section shall be construed to prohibit (1) a person from disclosing individually identifiable medical record information as permitted under section 38a-988, any other applicable state or federal law or in connection with a collectively bargained agreement, or (2) a health care provider from transferring individual identifiable medical record information for the purposes of clinical research, utilization review, quality review, performance improvement, billing for services or other functions performed by health care providers or their agents in support of direct patient care, provided (A) in the case of clinical research, no individually identifiable medical record information may be disclosed by the clinical researcher, unless the disclosure would otherwise be permitted, and (B) the entity to whom the information is transferred agrees not to disclose the information unless the disclosure would otherwise be permitted if made by the transferer. Nothing in this section shall be construed to prohibit a person from transferring

individually identifiable medical record information to another person as part of a consummated sale of that person to another person or consummated merger by that person with another person or to a successor in interest. For the purposes of this section, "insurance transaction" as used in section 38a-988 shall apply to any insurance including insurance for personal, family, household, business or professional needs, and "insurance institution" as used in said section 38a-988 includes self-insured employers for workers' compensation purposes and third-party administrators.

Sec. 10. Subsection (a) of section 38a-999 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) An insurance institution, agent or insurance support organization that regularly collects, uses or discloses medical record information, as defined in **[**subsection (r) of**]** section 38a-976, as amended by this act, shall develop and implement written policies, standards and procedures for the management, transfer and security of medical record information, including policies, standards and procedures to guard against the unauthorized collection, use or disclosure of medical record information by the insurance institution, agent or insurance support organization or any employee or agent thereof. Such policies, standards and procedures shall include:

(1) Limitation on access to medical record information by only those persons who need to use the medical record information in order to perform their jobs;

(2) Appropriate training for all employees identified in subdivision (4) of this subsection;

(3) Disciplinary measures for violations of the medical record information policies, standards and procedures;

(4) Identification of the job titles of persons that are authorized to use or disclose medical record information;

(5) Procedures for authorizing and restricting the collection, use or disclosure of medical record information;

(6) Methods for handling, disclosing, storing and disposing of medical record information;

(7) Periodic monitoring of the employees' compliance with the policies, standards and procedures in a manner sufficient for the insurance institution, agent or insurance support organization to determine compliance with this section and to enforce its policies, standards and procedures; and

(8) Additional protection against unauthorized disclosure of sensitive health information, which shall include information regarding: Sexually transmitted diseases; mental health; substance abuse; the human immunodeficiency virus and acquired immune deficiency syndrome; and genetic testing, including the fact that an individual has undergone a genetic test.

Sec. 11. Subsection (a) of section 38a-41 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) No insurance company or health care center shall do any insurance business or health care center business within this state until and except while it is permitted to do so under the terms of a license issued by the commissioner. Any such company desiring to obtain such a license shall make application to the commissioner, setting forth the line or lines of business **[**which**]** that it is seeking authorization to write. It shall file with the commissioner a certified copy of its charter or articles of association and evidence satisfactory to the commissioner that it has complied with the laws of the jurisdiction under which it is

organized, a statement of its financial condition in such form as is required by the commissioner, together with such evidence of its correctness as the commissioner requires and evidence of good management in such form as is required by the commissioner. Applicant companies licensed in and operated from administrative offices in one state but domiciled in another state, as permitted by the applicable state law, shall provide justification of such arrangement, satisfactory to the commissioner, which shall demonstrate that regulatory influence of the domiciliary supervisory official has not been diminished as a result of such arrangement. An applicant shall demonstrate an orderly pattern of growth in its marketing territories in the geographic region, with the exception of a newly formed health care center, and an expertise in marketing and servicing the lines of insurance or the health care center business it desires to write. It shall submit evidence of its ability to provide **[**continuant**]** continuous and timely claims settlement. If the information furnished is satisfactory to the commissioner and if all other requirements of law have been complied with, he may issue to such company a license permitting it to do business in this state. Each such license shall expire on the first day of May succeeding the date of its issuance, but may be renewed without any formalities except as required by the commissioner. Failure of a licensed company to exercise its authority to write a particular line or lines of business in this state for two consecutive calendar years may constitute sufficient cause for revocation of the company's authority to write those lines of business.

Sec. 12. Subsections (g) to (j), inclusive, of section 38a-90c of the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(g) (1) If the contract permits the managing general agent to settle claims on behalf of the insurer: **[**(1)**]** (A) All claims **[**must**]** shall be reported to the company in a timely manner; **[**(2)**]** (B) a copy of the

claim file shall be sent to the insurer at its request or as soon as it becomes known that the claim: **[**(A)**]** (i) Has the potential to exceed an amount determined by the commissioner or exceeds the limit set by the company, whichever is less; **[**(B)**]** (ii) involves a coverage dispute; **[**(C)**]** (iii) may exceed the managing general agent claims settlement authority; **[**(D)**]** (iv) is open for more than six months; or **[**(E)**]** (v) is closed by payment of an amount set by the company.

[(3)**]** (2) All claim files will be the joint property of the insurer and managing general agent. **[**. However,**]** except that upon an order of liquidation of the insurer such files shall become the sole property of the insurer or its estate and the managing general agent shall have reasonable access and the right to copy the files on a timely basis.

[(4)**]** (3) Any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

(h) Where electronic claims files are in existence, the contract **[**must**]** shall address the timely transmission of data.

(i) If the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits will not be paid to the managing general agent until one year after they are earned for property insurance and five years after they are earned on casualty insurance and not until the profits have been verified pursuant to section 38a-90d, as amended by this act.

(j) The managing general agent shall not: (1) Bind reinsurance or

retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules; (2) commit the insurer to participate in insurance or reinsurance syndicates; (3) appoint any producer or agent without **[**assuring**]** ensuring that the producer or agent is lawfully licensed to transact the type of insurance for which **[**he**]** such producer or agent is appointed; (4) without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one per cent of the insurer's policyholder's surplus as of December thirty-first of the last completed calendar year; (5) collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer, without prior approval of the insurer. If prior approval is given, a report **[**must**]** shall be promptly forwarded to the insurer; (6) jointly employ an individual who is employed with the insurer; (7) appoint a submanaging general agent; or (8) permit its subproducer or subagent to serve on the insurer's board of directors.

Sec. 13. Subsection (b) of section 38a-91kk of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(b) A captive insurance company may only take credit for the reinsurance of risks or portions of risks ceded to reinsurers that **[**complies**]** comply with the provisions of section 38a-85 or 38a-86.

Sec. 14. Subdivision (3) of subsection (a) of section 38a-130 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(3) Any controlling person of a domestic insurance company seeking to divest in any manner such person's controlling interest in such insurance company shall file with the commissioner and send to such insurance company a confidential notice of the proposed divestiture at least thirty **[**days'**]** days prior to such divestiture, except that if a statement set forth in subparagraph (A) of subdivision (2) of this subsection has been filed with the commissioner with respect to such transaction, such controlling person shall not be required to file or send such confidential notice. The notice shall remain confidential until the conclusion of the divestiture unless the commissioner determines that such confidential treatment will interfere with the enforcement of this section. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to establish the circumstances under which a controlling person shall be required to obtain the commissioner's prior approval of such divestiture.

Sec. 15. Subdivision (3) of subsection (a) of section 38a-193 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(3) (A) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. Any interest obligation relating to the repayment of any subordinated debt **[**must**]** shall be similarly subordinated. (B) The interest expenses relating to the repayment of any fully subordinated debt shall not be considered uncovered expenditures. (C) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner, shall not be considered a liability and shall be recorded as equity.

Sec. 16. Subsection (b) of section 38a-199 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(b) A hospital service corporation providing health care benefits to plan subscribers under the provisions of subsection (a) of this section may, upon obtaining the approval of the Insurance Commissioner as provided in section **[**38a-482**]** 38a-208: (1) Adjust the rates to be paid by any group or groups of its subscribers based upon past and prospective loss experience and may classify subscribers and groups of subscribers and determine rates with reference to standards for variations or risks or expenses which it may establish; (2) contract for the coordination of benefits with other hospital service corporations, medical service corporations or insurance companies to avoid duplication of benefits to be provided to its group subscribers; (3) make loans, grants or provide anything of value to a health care center covering all or part of the cost of health services provided to members; (4) contract with a health care center to provide insurance or similar protection to cover the cost of care provided through health care centers and to provide coverage in the event of the insolvency of the health care center; and (5) establish, maintain, own and operate health care centers as a line of business, provided that (A) aggregate investments hereafter made by such corporation shall not exceed ten per cent of such corporation's contingency reserve as of the date of the investment; (B) such investments shall not be repaid or recovered from rates charged by such corporation for its non-health-care-center lines of business; **[**,**]** and (C) the commissioner shall find, based upon evidence furnished by such corporation, that the financial condition of such corporation and the rates of its non-health-care-center subscribers are not unduly jeopardized by such investment. Subdivisions (1) and (2) shall be subject to such regulations as may be adopted by the Insurance Commissioner to establish guidelines of eligibility for experience rating and adoption of coordination of benefits clauses in health care contracts.

Sec. 17. Subsection (b) of section 38a-214 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective*

October 1, 2014):

(b) A medical service corporation providing health care benefits to plan subscribers under the provisions of subsection (a) of this section may, upon obtaining the approval of the Insurance Commissioner as provided in section **[**38a-488**]** 38a-218: (1) Adjust the rates to be paid by any group or groups of its subscribers based upon past and prospective loss experience and may classify subscribers and groups of subscribers and determine rates with reference to standards for variations of risks or expenses which it may establish; (2) contract for the coordination of benefits with other hospital service corporations, medical service corporations or insurance companies to avoid duplication of benefits to be provided to its group subscribers; (3) make loans, grants or provide anything of value to a health care center covering all or part of the cost of health services provided to members; (4) contract with a health care center to provide insurance or similar protection to cover the cost of care provided through health care centers and to provide coverage in the event of the insolvency of the health care center; and (5) establish, maintain, own and operate health care centers as a line of business, provided that (A) aggregate investments hereafter made by such corporation shall not exceed ten per cent of such corporation's contingency reserve as of the date of the investment; (B) such investments shall not be repaid or recovered from rates charged by such corporation for its non-health-care-center lines of business; **[**,**]** and (C) the commissioner shall find, based upon evidence furnished by such corporation, that the financial condition of such corporation and the rates of its non-health-care-center subscribers are not unduly jeopardized by such investment. Subdivisions (1) and (2) of this subsection shall be subject to such regulations as may be adopted by the Insurance Commissioner to establish guidelines of eligibility for experience rating and adoption of coordination of benefits clauses in health care benefit contracts.

Sec. 18. Subsection (b) of section 38a-490a of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible health plan, as that term is used in subsection (f) of section 38a-493, shall not be subject to the deductible limits set forth in this section.

Sec. 19. Subsection (b) of section 38a-516a of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(b) No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible health plan, as that term is used in subsection (f) of section **[**38a-493**]** 38a-520, shall not be subject to the deductible limits set forth in this section.

Sec. 20. Subsection (c) of section 38a-300 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(c) The provisions of sections 38a-295 to 38a-300, inclusive, shall not apply to: (1) Any policy **[**which**]** that is a security subject to federal jurisdiction; (2) any group policy covering a group of fifty or more lives at date of issue, other than a group credit life insurance policy or a group credit health insurance policy, except this shall not exempt any certificate issued pursuant to a group policy delivered or issued for delivery in this state; (3) any group annuity contract **[**which**]** that serves as a funding vehicle for pension, profit sharing or deferred compensation plans; (4) any form used in connection with a policy delivered or issued for delivery on a policy form **[**which**]** that has been

authorized for issuance by the commissioner prior to October 1, 1979, as to such policy form, except this shall not exempt any group policy or certificate issued thereunder unless the holders of such certificates are entitled to receive a summary plan description pursuant to the terms of the Federal Employee Retirement Income Security Act of 1974; or (5) the renewal of an annuity or an individual life or health insurance policy delivered or issued for delivery prior to the date any such form must be approved by the commissioner as readable.

Sec. 21. Subsection (a) of section 38a-416 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) No title insurer or title insurance agent may accept any order for, issue a title insurance policy to, or provide services to, an applicant if **[**it**]** such insurer or agent knows or has reason to believe that the applicant was referred to **[**it**]** such insurer or agent by any producer of title insurance business or by any associate of such producer, where the producer, the associate or both, have a financial interest in the title insurer or title agent to which business is referred unless the producer has disclosed to the buyer, seller, lender, the financial interest of the producer of title insurance business or associate referring the title insurance business. The disclosure **[**must**]** shall be made in writing on forms prescribed by the commissioner. The title insurer shall maintain the disclosure forms for a period of three years.

Sec. 22. Section 38a-423 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) A title insurer or title agent that issues a mortgagee's policy of title insurance on a loan made simultaneous with the purchase of all or part of the residential property securing the loan, where no owner's policy has been ordered, shall inform the borrower in writing that the mortgagee's policy does not protect the borrower, and that the

borrower may obtain an owner's title insurance policy for his protection. **[**This**]** Such notice **[**must**]** shall be provided before disbursement of the loan proceeds and before issuance of a mortgagee's policy **[**. The notice must**]** and shall be on a form prescribed by the commissioner.

(b) If the borrower elects not to purchase an owner's title insurance policy, the title insurer or title agent shall obtain from **[**him**]** the borrower a statement in writing that the notice has been received and that the borrower waives the right to purchase an owner's title insurance policy. If the **[**buyer**]** borrower refuses to provide the statement and waiver, the title insurer or title agent shall so note in the file. The statement and waiver **[**must**]** shall be on a form prescribed by the commissioner and **[**must**]** shall be retained by the title insurer or title agent for at least five years after receipt.

Sec. 23. Subsection (f) of section 38a-439 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(f) In the case of any plan of life insurance **[**which**]** that provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance **[**which**]** that is of such nature that minimum values cannot be determined by the methods described in subsections (a) to (e), inclusive, **[**then**]** of this section: (1) The commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as are the minimum benefits otherwise required by subsections (a) to (e), inclusive, of this section; (2) the commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds; and (3) the cash surrender values and paid-up nonforfeiture benefits provided by such plan **[**must**]** shall not be less than the minimum

values and benefits required for the plan computed by a method consistent with the principles of this section, as determined by regulations adopted by the commissioner in accordance with the provisions of chapter 54.

Sec. 24. Subdivision (1) of subsection (m) of section 38a-465g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(1) The policy was issued upon the owner's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is not less than twenty-four months. The time covered under a group policy **[**must**]** shall be calculated without regard to a change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship; or

Sec. 25. Subsection (p) of section 38a-479rr of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(p) The commissioner shall, in any order suspending the authority of a medical discount plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, **[**which must**]** that shall be met by the medical discount plan organization prior to reinstatement of its license to enroll new members. The commissioner may rescind or modify the order of suspension prior to the expiration of the suspension period.

Sec. 26. Subdivision (8) of subsection (a) of section 38a-483 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(8) A provision as follows: "TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for

which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment shall be paid .... (insert period for payment **[**which must**]** that shall not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."

Sec. 27. Subsection (a) of section 38a-484 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) No policy provision which is not subject to section 38a-483, as amended by this act, shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof **[**which**]** that are subject to sections 38a-481 to 38a-488, inclusive, as amended by this act.

Sec. 28. Subsection (c) of section 38a-513 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(c) Nothing in this chapter shall preclude the issuance of a group health insurance policy **[**which**]** that includes an optional life insurance rider, provided the optional life insurance rider **[**must**]** shall be filed with and approved by the Insurance Commissioner pursuant to section 38a-430. Any company offering such policies for sale in this state shall be licensed to sell life insurance in this state pursuant to the provisions of section 38a-41, as amended by this act.

Sec. 29. Section 38a-528 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) (1) As used in this section, "long-term care policy" means any

group health insurance policy or certificate delivered or issued for delivery to any resident of this state on or after July 1, 1986, **[**which**]** that is designed to provide, within the terms and conditions of the policy or certificate, benefits on an expense-incurred, indemnity or prepaid basis for necessary care or treatment of an injury, illness or loss of functional capacity provided by a certified or licensed health care provider in a setting other than an acute care hospital, for at least one year after a reasonable elimination period. A long-term care policy shall provide benefits for confinement in a nursing home or confinement in the insured's own home or both. Any additional benefits provided shall be related to long-term treatment of an injury, illness or loss of functional capacity. "Long-term care policy" shall not include any such policy or certificate which is offered primarily to provide basic Medicare supplement coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified accident coverage or limited benefit health coverage.

(2) (A) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any long-term care policy in this state may refuse to accept or make reimbursement pursuant to a claim for benefits submitted by or prepared with the assistance of a managed residential community, as defined in section 19a-693, in accordance with subdivision (7) of subsection (a) of section 19a-694 solely because such claim for benefits was submitted by or prepared with the assistance of a managed residential community.

(B) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center delivering, issuing for delivery, renewing, continuing or amending any

long-term care policy in this state shall, upon receipt of a written authorization executed by the insured, (i) disclose information to a managed residential community for the purpose of determining such insured's eligibility for an insurance benefit or payment, and (ii) provide a copy of the initial acceptance or declination of a claim for benefits to the managed residential community at the same time such acceptance or declination is made to the insured.

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center may deliver or issue for delivery any long-term care policy or certificate which has a loss ratio of less than sixty-five per cent for any group long-term care policy. An issuer shall not use or change premium rates for a long-term care policy or certificate unless the rates have been filed with the Insurance Commissioner. Deviations in rates to reflect policyholder experience shall be permitted, provided each policy form shall meet the loss ratio requirement of this section. Any rate filings or rate revisions shall demonstrate that anticipated claims in relation to premiums when combined with actual experience to date can be expected to comply with the loss ratio requirement of this section. On an annual basis, an insurer shall submit to the Insurance Commissioner an actuarial certification of the insurer's continuing compliance with the loss ratio requirement of this section. Any rate or rate revision may be disapproved if the commissioner determines that the loss ratio requirement will not be met over the lifetime of the policy form using reasonable assumptions.

(c) No such company, society, corporation or center may deliver or issue for delivery any long-term care policy without providing, at the time of solicitation or application for purchase or sale of such coverage, full and fair disclosure of the benefits and limitations of the policy. The provisions of this subsection shall not be applicable to: (1) Any long-term care policy **[**which**]** that is delivered or issued for delivery to one

or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, or the labor organizations; and (2) noncontributory plans.

(d) The Insurance Commissioner shall adopt regulations, in accordance with chapter 54, **[**which**]** that address (1) the insured's right to information prior to his replacing an accident and sickness policy with a long-term care policy, (2) the insured's right to return a long-term care policy to the insurer, within a specified period of time after delivery, for cancellation, and (3) the insured's right to accept by **[**his**]** the insured's signature, and prior to it becoming effective, any rider or endorsement added to a long-term care policy after the issuance date of such policy, provided (A) any regulations adopted pursuant to subdivisions (1) and (2) of this subsection shall not be applicable to (i) any long-term care policy **[**which**]** that is delivered or issued for delivery to one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof or for members or former members or a combination thereof, of the labor organizations, or (ii) noncontributory plans, and (B) any regulations adopted pursuant to subdivision (3) of this subsection shall not be applicable to any group long-term care policy. The Insurance Commissioner shall adopt such additional regulations as **[**he**]** the commissioner deems necessary in accordance with said chapter 54 to carry out the purpose of this section.

(e) The Insurance Commissioner may, upon written request by any such company, society, corporation or center, issue an order to modify or suspend a specific provision of this section or any regulation adopted pursuant thereto with respect to a specific long-term care

policy upon a written finding that: (1) The modification or suspension would be in the best interest of the insureds; (2) the purposes to be achieved could not be effectively or efficiently achieved without such modification or suspension; and (3) (A) the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care, (B) the policy is to be issued to residents of a life care or continuing care retirement community or other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such community, or (C) the modification or suspension is necessary to permit long-term care policies to be sold as part of, or in conjunction with, another insurance product. **[**, whenever**]** Whenever the commissioner decides not to issue such an order, **[**he**]** the commissioner shall provide written notice of such decision to the requesting party in a timely manner.

(f) Upon written request by any such company, society, corporation or center, the Insurance Commissioner may issue an order to extend the preexisting condition exclusion period, as established by regulations adopted pursuant to this section, for purposes of specific age group categories in a specific long-term care policy form whenever he makes a written finding that such an extension is in the best interest to the public. Whenever the commissioner decides not to issue such an order, **[**he**]** the commissioner shall provide written notice of such decision to the requesting party in a timely manner.

(g) The provisions of section 38a-19 shall be applicable to any such requesting party aggrieved by any order or decision of the commissioner made pursuant to subsections (e) and (f) of this section.

Sec. 30. Subsection (q) of section 38a-551 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(q) "Deductible" means the amount of covered expenses **[**which**]** that must be accumulated during each calendar year before benefits become payable as additional covered expenses incurred.

Sec. 31. Subdivision (2) of section 38a-567 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(2) Except in the case of a late enrollee who has failed to provide evidence of insurability satisfactory to the insurer, the plan or arrangement may not exclude any eligible employee or dependent who would otherwise be covered under such plan or arrangement on the basis of an actual or expected health condition of such person. No plan or arrangement may exclude an eligible employee or eligible dependent who, on the day prior to the initial effective date of the plan or arrangement, was covered under the small employer's prior health insurance plan or arrangement pursuant to workers' compensation, continuation of benefits pursuant to section 38a-554 or other applicable laws. The employee or dependent **[**must**]** shall request coverage under the new plan or arrangement on a timely basis and such coverage shall terminate in accordance with the provisions of the applicable law.

Sec. 32. Subsection (a) of section 38a-688a of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) Notwithstanding the requirements of sections 38a-389 and 38a-688 with respect to personal risk insurance with the exception of residual market rates, and on and after July 1, 2006, and until July 1, 2015, an insurer may file a rate with the Insurance Commissioner pursuant to this section and such rate shall take effect the date it is filed provided the rate provides for an overall state-wide rate increase or decrease of not more than six per cent in the aggregate and not more than a fifteen per cent increase in any individual territory for all

coverages that are subject to the filing. Such **[**per cent**]** percentage limits shall not apply on an individual insured basis. Not more than one filing may be made by an insurer pursuant to this section within any twelve-month period unless the filing, when combined with one or more filings made by the insurer within the preceding twelve months, does not result in an overall state-wide increase or decrease of more than six per cent in the aggregate and not more than a fifteen per cent increase in any individual territory for all coverages that are subject to the filing.

Sec. 33. Subdivision (5) of section 38a-760g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(5) Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report **[**must**]** shall be promptly forwarded to the reinsurer;

Sec. 34. Subsection (d) of section 38a-909 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(d) If any legal action against an employee for which indemnity may be available under this section is settled prior to final adjudication on the merits, the insurer **[**must**]** shall pay the settlement amount on behalf of the employee or indemnify the employee for the settlement amount unless the commissioner determines:

(1) That the claim did not arise out of or by reason of the employee's duties or employment; or

(2) That the claim was caused by the intentional or wilful and wanton misconduct of the employee.

Sec. 35. Subsection (c) of section 38a-954 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(c) Claimants residing in this state may file claims with the liquidator or ancillary receiver, if any, in this state or with the domiciliary liquidator, if the domiciliary law permits. The claims **[**must**]** shall be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

Sec. 36. Subsection (a) of section 38a-957 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) In a liquidation proceeding begun in this state against an insurer domiciled in this state, claimants residing in foreign countries or in states not reciprocal states **[**must**]** shall file claims in this state, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, provided a claim filing procedure is established in the ancillary proceeding, or with the domiciliary liquidator. Claims **[**must**]** shall be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

Sec. 37. Subsection (a) of section 38a-958 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) Promptly after the appointment of the commissioner as ancillary receiver for an insurer not domiciled in this state, the commissioner shall determine whether there are claimants residing in this state who are not protected by guaranty funds and if so, whether the protection of such claimants requires the establishing of a claim filing procedure in the ancillary proceeding. If a claim filing procedure is established,

claimants against the insurer who reside within this state may file claims either with the ancillary receiver, if any, in this state, or with the domiciliary liquidator. Claims **[**must**]** shall be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

Sec. 38. Subdivision (7) of section 38a-1080 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(7) "Health carrier" means an insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity subject to the insurance laws and regulations of the state or the jurisdiction of the commissioner that contracts or offers to contract to provide, deliver, pay for or reimburse any of the costs of health care services;

Sec. 39. Subparagraphs (A)(viii) and (A)(ix) of subdivision (1) of subsection (b) of section 38a-1081 of the 2014 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(viii) The Commissioner of Social Services, the Special Advisor to the Governor on Healthcare Reform, the Secretary of the Office of Policy and Management and the Healthcare Advocate, or their designees, who shall serve as ex-officio, voting board members; and

(ix) The Insurance Commissioner and the Commissioner of Public Health, or their designees, who shall serve as ex-officio, nonvoting board members.

Sec. 40. Subdivision (5) of subsection (k) of section 38a-14 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(5) A person identified in subdivision (2) of this subsection shall be entitled to an award of attorney's fees and costs if such person is the prevailing party in a civil **[**cause of**]** action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this section and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

Sec. 41. Subdivision (5) of subsection (i) of section 38a-91hh of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(5) A person identified in subdivision (2) of this subsection shall be entitled to an award of attorney's fees and costs if he is the prevailing party in a civil **[**cause of**]** action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this section and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

Sec. 42. Subdivision (3) of subsection (i) of section 38a-465e of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(3) A person identified in subdivision (1) or (2) of this subsection shall be entitled to an award of attorney's fees and costs if such person is the prevailing party in a civil **[**cause of**]** action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this section and the party bringing the action was not substantially justified in doing so. For the purpose of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

Sec. 43. Subdivision (3) of subsection (f) of section 38a-465j of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(3) A person identified in subdivision (1) of this subsection shall be entitled to an award of attorney's fees and costs if such person is the prevailing party in a civil **[**cause of**]** action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this part and the party bringing the action was not substantially justified in doing so. For the purpose of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

Sec. 44. Subsection (e) of section 38a-465e of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(e) (1) Upon determining that an examination should be conducted, the commissioner shall issue an examination warrant appointing one or more examiners to perform such examination and instructing them as to its scope. In conducting the examination, the examiner shall use methods common to the examination of any life settlement licensee and shall use guidelines and procedures set forth in an examiners' handbook adopted by a national organization.

(2) Each licensee or person from whom information is sought, its officers, directors and agents shall provide to the examiners timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, **[**papers**]** <u>workpapers</u>, documents, assets and computer or other recordings relating to the property, assets, business and affairs of the licensee being examined. The officers, directors, employees and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal by a licensee or its officers, directors, employees or

agents to submit to an examination or to comply with any reasonable written request of the commissioner shall be grounds for suspension, refusal or nonrenewal of any license or authority held by the licensee to engage in the life settlement business or other business subject to the commissioner's jurisdiction. Any proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to sections 38a-17 to 38a-19, inclusive.

(3) The commissioner shall have the power to issue subpoenas, administer oaths and examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence.

(4) When making an examination under this part, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.

(5) Nothing contained in this section shall be construed to limit the commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(6) All final or preliminary examination reports, examiner or licensee **[**work papers**]** workpapers or other documents, or any other information discovered or developed during the course of an examination shall be kept confidential, pursuant to section 38a-69a.

Sec. 45. Subsection (g) of section 38a-465e of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(g) Except as otherwise provided in this section, all examination reports, **[**working papers**]** workpapers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the commissioner or any other person in the course of an examination made under this section, or in the course of analysis or investigation by the commissioner of the financial condition or market conduct of a licensee, shall be confidential by law and privileged and shall not be subject to section 1-210, subject to subpoena, or subject to discovery or be admissible in evidence in any civil action. The commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties. The licensee being examined shall have access to all documents used to make the report.

Sec. 46. Section 38a-201 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

No contract between any such corporation and subscribers shall entitle more than one person to services, except that such contract may be issued for service to a subscriber and **[**wife, to a subscriber and husband**]** spouse, to a subscriber and family, to a subscriber and dependent or dependents related by blood, marriage or adoption or to a subscriber and ward. Such contract with a subscriber shall be in writing and a copy thereof furnished to each subscriber. Each such contract shall contain the following provisions: (1) A statement of the amount payable to the corporation by the subscriber and the manner in which such amount is payable; (2) a statement of the nature of the services to be furnished and the period during which they will be furnished, and, if there are any services to be excepted, a detailed

statement of such exceptions; (3) a statement of terms and conditions upon which the contract may be cancelled or otherwise terminated at the option of either party; (4) a statement that the contract includes the endorsement thereon and attached papers, if any, and contains the entire contract; (5) a statement that no statement by the subscriber in **[**his**]** the subscriber's application for a contract shall void the contract or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such contract; (6) a statement of the period of grace **[**which**]** that will be allowed the subscriber for making any payment due under the contract, which period shall not be less than ten days; and (7) a statement that no action at law based upon or arising out of the physician-patient relationship shall be maintained against a nonprofit hospital service corporation.

Sec. 47. Section 38a-217 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

No single contract between any such corporation and its subscribers shall entitle more than one person to indemnity, except that a single contract may be issued to subscriber and **[**wife, to subscriber and husband**]** spouse, to subscriber and family by marriage or adoption or to subscriber and ward. Such contract shall be in writing and a copy thereof shall be furnished to each subscriber and shall contain the following provisions: **[**(a)**]** (1) A statement of the amount payable to the corporation by the subscriber and the manner in which such amount is payable; **[**(b)**]** (2) a statement of the amount of indemnity to be furnished and the period during which it will be furnished, and, if there are to be exceptions, a detailed statement of such exceptions; **[**(c)**]** (3) a statement of terms and conditions upon which the contract may be cancelled or otherwise terminated at the option of either party; **[**(d)**]** (4) a statement that the contract includes the endorsements thereon and attached papers, if any, and contains the entire contract; **[**(e)**]** (5) a

statement that no statements by the subscriber in **[**his**]** the subscriber's application for a contract shall void the contract or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such contract; **[**(f)**]** (6) a statement of the period of grace **[**which**]** that will be allowed the subscriber for making any payment due under the contract, which period shall not be less than ten days; **[**(g)**]** and (7) a statement that no action at law based upon or arising out of the physician-patient relationship shall be maintained against a nonprofit medical service corporation.

Sec. 48. Section 38a-284 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

Any minor of the age of fifteen years or more may, notwithstanding such minority, contract for life, health and accident insurance on **[**his**]** such minor's person for **[**his**]** such minor's benefit or for the benefit of **[**his**]** such minor's father, mother, **[**husband, wife**]** spouse, child, brother or sister and may exercise all such contractual rights with respect to any such contract of insurance as might be exercised by a person of full legal age and may at any time surrender **[**his**]** such minor's interest in any such insurance or give a valid discharge for any benefit accruing or money payable thereunder.

Sec. 49. Subdivision (1) of section 38a-341 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(1) "Policy" means an automobile liability insurance policy providing among other coverage bodily injury liability, delivered or issued for delivery in this state, insuring a single individual or **[**husband and wife**]** spouses resident of the same household, as named insured, and under which the insured vehicles therein designated are of the following types only: (A) A motor vehicle of the private passenger or station wagon type that is not used as a public or livery

conveyance for passengers, nor rented to others, or (B) any other four-wheel motor vehicle with a load capacity of fifteen hundred pounds or less which is not used in the occupation, profession or business of the insured, provided said sections shall not apply (i) to any policy insuring more than four automobiles, or (ii) to any policy covering garage, automobile sales agency, repair shop, service station or public parking place operation hazards, or (iii) to any policy of insurance issued principally to cover personal or premises liability of an insured even though the insurance may also provide some incidental coverage for liability arising out of the ownership, maintenance or use of a motor vehicle on the premises of the insured or on the ways immediately adjoining the premises;

Sec. 50. Section 38a-482 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

No individual health insurance policy shall be delivered or issued for delivery to any person in this state unless: (1) The entire money and other considerations therefor are expressed therein; (2) the time at which the insurance takes effect and terminates is expressed therein; (3) such policy purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two or more eligible members of such family, including **[**husband, wife**]** spouse, dependent children or any children as specified in section 38a-497, and any other person dependent upon the policyholder; (4) the style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lowercase unspaced alphabet length not less than one hundred and twenty-point, the word "text" as herein used including all

printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions; (5) the exceptions and reductions of indemnity are set forth in the policy and, except as provided in section 38a-483, as amended by this act, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS", provided, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; (6) each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and (7) such policy contains no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

Sec. 51. Section 38a-540 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

In any case in which **[**a husband and wife**]** spouses are employed by the same employer and, by reason of their employment, are both eligible for coverage under the terms of any health insurance policy issued under a group plan and by an insurance company, hospital **[**or**]** service corporation, medical service corporation, health care center or fraternal benefit society, such **[**husband and wife**]** spouses shall not be required as a condition of their employment or as a condition of coverage under such plan, to pay any premium **[**which**]** that does not result in greater coverage than would be provided if only one of them were eligible to participate in such group plan.

Sec. 52. Section 38a-541 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective October 1, 2014*):

Every health insurance policy issued under a group insurance plan and by an insurance company, hospital **[**or**]** service corporation, medical service corporation, health care center or fraternal benefit society, delivered, issued for delivery or renewed in this state shall allow the spouse of any employee participating in such or any other group insurance plan offered by the same employer to be covered as an employee in addition to being covered as a dependent of such participating employee, except that benefits provided under such combined coverage of the employee as an employee and as a dependent shall not be in excess of one hundred per cent of the charge for the covered expense or service. The provisions of this section shall apply only where **[**a husband and wife**]** spouses are employed by the same employer and by reason of their employment are both participating in a group insurance plan. Nothing in this section shall alter or impair existing group health insurance policies or contracts **[**which**]** that have been established pursuant to an agreement **[**which**]** that resulted from collective bargaining, and the provisions required by this section shall become effective upon the next regular renewal and completion of such collective bargaining agreement.

Sec. 53. Subsection (e) of section 38a-72 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(e) An insurer licensed in this state and issuing or reinsuring in this state policies of financial guaranty insurance, as defined in subdivision (1) of section 38a-92a shall **[**, notwithstanding the provisions of subsection (a) of this section, be deemed to meet the combined capital and surplus requirements for transacting financial guaranty insurance business during the period between October 1, 1993, and July 1, 1995, if it has combined capital and surplus of forty-five million dollars, which includes paid-in capital of at least two million five hundred thousand

dollars. On or after July 1, 1995, every licensed financial guaranty insurance corporation must**]** fully comply with the requirements of subsection (a) of this section.

Sec. 54. Section 38a-479bbb of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) Except as provided in subsection (d) of this section, no person shall act as a pharmacy benefits manager in this state without first obtaining a certificate of registration from the commissioner.

(b) Any person seeking a certificate of registration shall apply to the commissioner, in writing, on a form provided by the commissioner. The application form shall state (1) the name, address, official position and professional qualifications of each individual responsible for the conduct of the affairs of the pharmacy benefits manager, including all members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association and any other person who exercises control or influence over the affairs of the pharmacy benefits manager, and (2) the name and address of the applicant's agent for service of process in this state.

(c) Each application for a certificate of registration shall be accompanied by (1) a nonrefundable fee of fifty dollars, and (2) evidence of a surety bond in an amount equivalent to ten per cent of one month of claims in this state over a twelve-month average, except that such bond shall not be less than twenty-five thousand dollars or more than one million dollars.

(d) Any pharmacy benefits manager operating as a line of business or affiliate of a health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society

licensed in this state or any affiliate of such health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society shall not be required to obtain a certificate of registration. Such health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society shall notify the commissioner annually, in writing, on a form provided by the commissioner, that it is affiliated with or operating a business as a pharmacy benefits manager.

[(e) Any person acting as a pharmacy benefits manager on January 1, 2008, and required to obtain a certificate of registration under subsection (a) of this section, shall obtain a certificate of registration from the commissioner not later than April 1, 2008, in order to continue to do business in this state.**]**

Sec. 55. Subsection (d) of section 38a-481 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(d) For the purposes of this section**[**: (1) "Loss ratio"**]** "loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations. **[**; and**]**

[(2) "Experience period" means the calendar year for which a loss ratio guarantee is calculated.**]**

Sec. 56. Subsection (a) of section 38a-712 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) Each insurance company authorized or permitted to do business in this state and each residual market mechanism established pursuant to section 38a-329 shall report to the Insurance Commissioner (1) any failure on the part of an insurance producer or **[**excess line**]** surplus lines broker to remit premiums for policies or endorsements issued to

insureds directly or through the producer within thirty days following the due date of the account of the producer with the company, its state agent or managing general agent, or (2) whenever a check issued by such producer to the company or residual market mechanism is returned for insufficient funds or otherwise dishonored and remains outstanding fifteen days following receipt of such return.

Sec. 57. Subsection (a) of section 38a-488a of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for the diagnosis and treatment of mental or nervous conditions. For the purposes of this section, "mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) intellectual **[**disability**]** disabilities, (2) specific learning disorders, (3) motor **[**skills**]** disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) **[**additional**]** other conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (b) of section 38a-488b.

Sec. 58. Subsection (a) of section 38a-514 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu

thereof (*Effective October 1, 2014*):

(a) Except as provided in subsection (j) of this section, each group health insurance policy, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for the diagnosis and treatment of mental or nervous conditions. For the purposes of this section, "mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) intellectual **[**disability**]** disabilities, (2) specific learning disorders, (3) motor **[**skills**]** disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) **[**additional**]** other conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", except that coverage for an insured under such policy who has been diagnosed with autism spectrum disorder prior to the release of the fifth edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders" shall be provided in accordance with subsection (i) of section 38a-514b.

Sec. 59. Section 38a-702q of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

Except as provided in section 38a-702g and section 38a-702n, sections 38a-702a to 38a-702r, inclusive, shall not apply to **[**excess and surplus lines agents and**]** surplus lines brokers licensed pursuant to **[**sections 38a-740 to 38a-745, inclusive, and section**]** section 38a-769 or 38a-794, as amended by this act.

Sec. 60. Subsections (a) and (b) of section 38a-743 of the general

statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) Every person, firm, association or corporation licensed pursuant to the provisions of **[**sections 38a-741 to 38a-744, inclusive, and**]** section 38a-794, as amended by this act, shall pay to the commissioner on May first of each year a sum equal to four per cent of the gross premiums charged the insureds by the insurers during the period from January first to March thirty-first of that year, and on August first of each year a sum equal to four per cent of the gross premiums charged the insured by the insurers during the period from April first to June thirtieth of that year, on November first of each year a sum equal to four per cent of the gross premiums charged the insureds by the insurers during the period from July first to September thirtieth of that year and on February first of each year a sum equal to four per cent of the gross premiums charged the insureds by the insurers during the period from October first to December thirty-first of the preceding year, for insurance procured by such licensee pursuant to such license, less the amount of such premiums returned to such insureds, except that the premium tax shall not apply to any policy issued to the state of Connecticut or any agency of the state or to any policy issued to any town, or agency of such town or special taxing district when such town, agency or department thereof or special taxing district appears in the policy as the named insured and as such is responsible for the payment of premiums shown on such policy. Each licensee shall also file on May first, August first, November first, and February first a return, in the form described by the commissioner, showing such information as the commissioner deems necessary. The provisions of this subsection shall not apply to nonadmitted insurance, as defined in subsection (b) of this section, that is procured, continued or renewed on or after July 1, 2011.

(b) For purposes of this subsection and subsections (c) to (g),

inclusive, of this section:

(1) "Home state" means home state, as defined in Section 527 of the Nonadmitted and Reinsurance Reform Act of 2010;

(2) "Licensee" means a person, firm, association or corporation that is licensed pursuant to the provisions of **[**sections 38a-741 to 38a-744, inclusive, and**]** section 38a-769 or 38a-794, as amended by this act, and that is a surplus lines broker, as defined in Section 527 of the Nonadmitted and Reinsurance Reform Act of 2010;

(3) "Nonadmitted and Reinsurance Reform Act of 2010" means Sections 511 to 542, inclusive, of the Dodd-Frank Wall Street Reform and Consumer Protection Act, P.L. 111-203, as amended from time to time;

(4) "Nonadmitted insurance" means nonadmitted insurance, as defined in Section 527 of the Nonadmitted and Reinsurance Reform Act of 2010; and

(5) "Nonadmitted insurer" means a nonadmitted insurer, as defined in Section 527 of the Nonadmitted and Reinsurance Reform Act of 2010.

Sec. 61. Section 38a-770 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

Whenever the Insurance Commissioner receives an application for an initial license or license renewal, pursuant to the requirements of sections 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, **[**38a-741 to 38a-744, inclusive,**]** 38a-769, 38a-771 to 38a-776, inclusive, as amended by this act, 38a-786, 38a-790, 38a-792 and 38a-794, as amended by this act, **[**which**]** that is not accompanied by the required fees, the commissioner shall return such application together with all accompanying fees, unless the commissioner, at the

commissioner's discretion, chooses to invoice any such fees not submitted with the initial or renewal applications. Whenever the Insurance Commissioner receives an application accompanied by the required fees accepted by the commissioner, all examination and filing fees are deemed earned.

Sec. 62. Section 38a-771 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) Any person, firm, partnership, association or corporation holding a license issued pursuant to sections 38a-702j, 38a-703 to 38a-716, inclusive, 38a-731 to 38a-735, inclusive, **[**38a-741 to 38a-745, inclusive,**]** 38a-769 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794, as amended by this act, or holding a license in the name of a trade name shall notify the Insurance Commissioner, in writing, not later than thirty days after any: (1) Change in business or residence address; (2) change in employer; (3) change in name; or (4) change in licensed members of a firm, partnership, association or officers of a corporation as stated in the application for license.

(b) Any person, firm, partnership, association or corporation, or any person, firm, partnership, association or corporation acting as a trade name, holding a license issued pursuant to sections 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, **[**38a-741 to 38a-745, inclusive,**]** 38a-769 to 38a-777, inclusive, as amended by this act, 38a-786, 38a-790, 38a-792 and 38a-794, as amended by this act, shall notify the Insurance Commissioner, in writing, not later than thirty days after any bankruptcy proceeding or the conviction of a felony, or any administrative action taken against such licensee in another state not later than thirty days after the entering of the administrative order in that state. Such notification shall be accompanied by all supporting documentation.

(c) If, upon investigation, the commissioner determines that a

producer has violated the provisions of subsection (b) of this section, the commissioner may, following a hearing as specified in section 38a-774, impose a fine upon and suspend or revoke the license of the producer.

Sec. 63. Section 38a-772 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

Any person wilfully misrepresenting any fact required to be disclosed in any application or in any other form, paper or document required to be filed with the commissioner in connection with an application for any license issued by the commissioner pursuant to sections 38a-702j, 38a-703 to 38a-718, inclusive, 38a-731 to 38a-735, inclusive, **[**38a-741 to 38a-745, inclusive,**]** 38a-769 to 38a-776, inclusive, 38a-786, 38a-790, 38a-792 and 38a-794, as amended by this act, shall be fined not more than four thousand dollars or imprisoned not more than six months, or both.

Sec. 64. Section 38a-777 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

Any surplus lines broker licensee under **[**sections 38a-741 to 38a-744, inclusive, or section**]** section 38a-769 or 38a-794, as amended by this act, who negotiates, continues or renews any contract for insurance **[**in**]** from any unauthorized **[**company**]** insurer, and who fails to make and file the statements required under section 38a-741, or who wilfully makes a false statement, or who negotiates, continues or renews any such contract of insurance after the revocation or during the suspension of the licensee's license, shall forfeit the license if not previously revoked and shall be fined not more than four thousand dollars or imprisoned not more than six months, or both.

Sec. 65. Section 38a-15 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective October 1, 2014*):

(a) The commissioner shall, as often as the commissioner deems it expedient, undertake a market conduct examination of the affairs of any insurance company, health care center, third-party administrator, as defined in section 38a-720, or fraternal benefit society doing business in this state.

(b) To carry out the examinations under this section, the commissioner may appoint, as market conduct examiners, one or more competent persons, **[**not officers**]** who shall not be officers of, or connected with or interested in, any insurance company, health care center, third-party administrator or fraternal benefit society, other than as a policyholder. In conducting the examination, the commissioner, the commissioner's actuary or any examiner authorized by the commissioner may examine, under oath, the officers and agents of such **[**an**]** insurance company, health care center, third-party administrator or fraternal benefit society and all persons deemed to have material information regarding the company's, center's, administrator's or society's property or business. Each such company, center, administrator or society, its officers and agents, shall produce the books and papers, in its or their possession, relating to its business or affairs, and any other person may be required to produce any book or paper **[**, in his**]** in such person's custody, deemed to be relevant to the examination, for the inspection of the commissioner, **[**his**]** the commissioner's actuary or examiners, when required. The officers and agents of the company, center, **[**or association**]** administrator or society shall facilitate the examination and aid the examiners in making the same so far as it is in their power to do so.

(c) Each market conduct examiner shall make a full and true report of each market conduct examination made by such examiner, which shall comprise only facts appearing upon the books, papers, records or documents of the examined company, center, administrator or society

or ascertained from the sworn testimony of its officers or agents or of other persons examined under oath concerning its affairs. The examiner's report shall be presumptive evidence of the facts therein stated in any action or proceeding in the name of the state against the company, center, administrator or society, its officers or agents. The commissioner shall grant a hearing to the company, center, administrator or society examined **[**,**]** before filing any such report **[**,**]** and may withhold any such report from public inspection for such time as the commissioner deems proper. The commissioner may, if **[**he**]** the commissioner deems it in the public interest, publish any such report, or the result of any such examination contained therein, in one or more newspapers of the state.

(d) All the expense of any examination made under the authority of this section, other than examinations of domestic insurance companies and domestic health care centers, shall be paid by the company, center, administrator or society examined, and domestic insurance companies and other domestic entities examined outside the state shall pay the traveling and maintenance expenses of examiners.

Sec. 66. Subdivision (1) of subsection (b) of section 38a-513f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2014*):

(1) Not later than October first, annually, provide to an employer sponsoring such policy, free of charge, the following information for the most recent thirty-six-month period or for the entire period of coverage, whichever is shorter, ending not more than sixty days prior to the date of the **[**request**]** provision of such information, in a format as set forth in subdivision (3) of this subsection:

(A) Complete and accurate medical, dental and pharmaceutical utilization data, as applicable;

(B) Claims paid by year, aggregated by practice type and by service category, each reported separately for in-network and out-of-network providers, and the total number of claims paid;

(C) Premiums paid by such employer by month; and

(D) The number of insureds by coverage tier, including, but not limited to, single, two-person and family including dependents, by month;

Approved June 13, 2014